be required to bill using codes established by the Department, except when the EPSDT RN screener is an employee of a rural health clinic, Indian Health Clinic, or federally qualified health clinic. (7-1-94)

i. One (1) screen at or by age one (1) month, two (2) months, three (3) months, four (4) months, six (6) months and nine (9) months. (8-1-92)

ii. One (1) screen at or by age twelve (12) months, fifteen (15) months, eighteen (18) months, and twenty-four (24) months. (8-1-92)

iii. One (1) screen at or by age three (3) years, age four (4) years and age five (5) years. (8-1-92)

iv. One (1) screen at or by age six (6) years, age eight (8) years, age ten (10) years, age twelve (12) years and age fourteen (14) years. (8-1-92)

v. One (1) screen at or by age sixteen (16) years, age eighteen (18) years and age twenty (20) years. (8-1-92)

vi. One (1) screen at initial program entry, up to the recipient's twenty-first (21st) birthday. (8-1-92)

b. Interperiodic medical screens are screens that are done at intervals other than those identified in the basic medical periodicity schedule in Subsection 100.02.a., and must be performed by physician or physician extender. Interperiodic screens will be required to be billed using the correct Physician's Current Procedural Terminology (CPT) under section "Evaluation and Management". (8-1-92)

i. Interperiodic screens will be performed when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. (8-1-92)

ii. Interperiodic screening examinations may occur in children who have already been diagnosed with an illness or condition, and there is indication that the illness or condition may have become more severe or changed sufficiently, so that the further examination is medically necessary. (8-1-92)

c. Developmental screening is considered part of every routine initial and periodic examination. If the screening identifies a developmental problem then a developmental assessment will be ordered by the physician and be conducted by qualified professionals. (1-27-91)

d. EPDST RN screeners will routinely refer all clients to primary care providers. EPDST clients ages two (2) weeks to two (2) years shall receive at least one (1) of their periodic or inter-periodic screens annually from a physician or physician extender unless otherwise medically indicated. A parent or guardian may choose to waive this requirement. EPDST RN screeners will refer clients for further evaluation, diagnosis and treatment to appropriate services (e.g. physician, registered dietitian, developmental evaluation, speech, hearing and vision evaluation, blood lead level evaluation). Efforts shall be made to assure that routine screening will not be duplicated for children receiving routine medical care by a physician. (3-22-93)

03. Vision Services. (8-1-92)

a. The Department will provide vision screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate vision screen. The guidelines coincide with certain scheduled medical screens, as specified in Subsection 100.02., the vision screen is considered part of the medical screening service, (i.e. eyechart). (8-1-92)

b. The Department will pay for one (1) eye examination by an opthalmologist or optometrist during any twelve (12) month period for each eligible recipient to determine the need for glasses to correct or treat refractive error as outlined in Section 122. (8-1-92)

c. Each eligible MA recipient, following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error, can receive one (1) pair of eyeglasses per year, except in the following circumstances: (11-10-81)

i. In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize a second eye examination to determine that visual change; or (2-15-86)

ii. The Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less than the cost of new frames if the provider indicates one of these reasons on his claim. If repair costs are greater than the cost of new frames, new frames may be authorized. (2-15-86)

04. Hearing Aids and Services. The Department will provide hearing screening services according to the recommended guidelines of the AAP. (8-1-92)

a. The screen administered will be an age-appropriate hearing screen. The guidelines coincide with certain scheduled medical screens, in accordance with Subsection 100.02., the hearing screen is considered part of the medical screening service. (8-1-92)

b. EPSDT hearing services will pay for audiology services and supplies ordered by a licensed physician and supplied by a physician or certified audiologist, in accordance with Section 108., with the following exceptions: (8-1-92)

i. When binaural aids are requested they may be authorized if documented to the Department's satisfaction, that the child's ability to learn would be severely restricted. (8-1-92)

ii. When replacement hearing aids are requested, they may be authorized if the requirements in Subsections 108.03.a. through 108.03.d. are met. (8-1-92)

iii. The Department will purchase additional ear molds after the initial six (6) months to one (1) year period if medically necessary. Requests in excess of every six (6) months will require prior authorization and documentation of medical need from either the attending physician or audiologist. (8-1-92)

05. EPSDT Registered Nurse Screener. A registered nurse (RN) who is currently licensed to practice in Idaho, and who meets the following provisions: (3-22-93)

a. Can produce proof of completion of the Medicaid Child Health Assessment training course (or equivalent as approved by Medicaid) that: (3-22-93)

i. Prepares the RN to identify the difference between screening, diagnosis and treatment; and prepares the RN to appropriately screen and differentiate between normal and abnormal findings. (3-22-93)

ii. Includes at least five (5) days didactic instruction in child health assessment, accompanied by a component of supervised clinical practice. (3-22-93)

b. Is employed by a physician, district health department, rural health clinic, Indian Health Clinic, or federally qualified health clinic in order to provide linkage to primary care services. The employers must have a signed Medical Provider Agreement and Provider Number. (3-22-93)

c. Has an established agreement with a physician or nurse practitioner for consultation on an as-needed basis. (3-22-93)

06. Private Duty Nursing Services. Private Duty Nursing Service provided by an Idaho licensed nurse to certain eligible children for whom the need for such service has been identified in an EPSDT screen. Private Duty Nursing is one nurse dedicated to one hundred percent (100%) of his time to the care of one recipient at the time Private Duty Nursing service is given. The nursing needs cannot be services that can be performed by a Certified Nursing Assistant as in Section 146., but must be of such a technical nature that the Idaho Nurse Practice Act, Rules, Regulations, or Policy require the service to be provided by an Idaho Licensed Professional Nurse, (RN) or by an Idaho Licensed Practical Nurse LPN, and require more individual and continuous care than is available from a visiting nurse (Home Health visit). Private Duty Nursing Service must be authorized by the Bureau of Medicaid Policy and Reimbursement prior to delivery of service. (7-1-94)

a. Services needed must include at least one (1) of the following nursing tasks: (1-27-91)

i. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material; or (7-1-94)

ii. The maintenance of volume ventilators including associated tracheotomy care; or (1-27-91)

iii. Tracheotomy and oral pharyngeal suctioning; or (1-27-91)

iv. Maintenance and monitoring of an IV site and administration of IV fluids and/or nutritional supplements which are to be administered on a continuous, or daily basis. (1-27-91)

v. A licensed nursing assessment of the child's health is required prior to the administration of a non-routine medication. Non-routine medication is medication for which the administration and amount given to a patient is subject to the findings of a licensed nurse's assessment. Non-routine medication necessary for a health assessment must be required more frequently than once per day for unstable chronic conditions. The fragile health and medication status are so complex that a certified nurse's aide could not be instructed to assist with medication according to the rules and regulations of the Idaho Board of Nursing. (8-1-92)

b. Private Duty Nursing Services may be provided only in the recipient's personal residence or when normal life activities take the recipient outside of this setting. Examples of normal life activities would be those hours a recipient would be outside the home setting to attend school or visit their assessment physician. However, if a recipient requests this service only to attend school or other activities outside of the home, but does not need such services in the home, private duty nursing will not be authorized. The following are specifically excluded as personal residences: (8-1-92)

i. Licensed Nursing Facilities (NF); and (7-1-94)

ii. Licensed Intermediate Care Facilities for the Mentally Retarded (ICF/MR); and (1-27-91)

iii. Licensed Residential Care Facilities; and (1-27-91)

iv. Licensed professional foster homes; and (1-27-91)

v. Licensed hospitals; and (1-27-91)

vi. Public or private school. (1-27-91)

c. Services delivered must be in a written plan of care, and the plan of care must: (1-27-91)

i. Include all aspects of the medical, licensed, and personal care services necessary to be performed, including the amount, type, and frequency of such service; and (1-27-91)

ii. Must be approved and signed by the attending physician; and (1-27-91)

iii. Must be revised and updated as recipient's needs change, but at least quarterly, and must be submitted to the Medicaid Program. (7-1-94)

d. Physician responsibilities: (1-27-91)

i. Provide the Department the necessary medical information in order to establish the recipient's medical eligibility for services based on an EPSDT medical screen. (1-27-91)

ii. Order all services to be delivered by the private duty nurse. (1-27-91)

iii. Sign and date all orders, and the recipient's care plan. (1-27-91)

iv. Update recipient's care planquarterly, sign and record date of plan approval. (7-1-94)

v. Determine if the combination of Private Duty Nursing Services along with other community resources are sufficient to ensure the health or safety of the recipient. If it is determined that the resources are not sufficient to ensure the health and safety of the recipient, notify the family and the Department and assist in placement of the recipient in the appropriate medical facility. (1-27-91)

e. Nurse responsibilities: (1-27-91)

i. Notify the physician immediately of any significant changes in the recipient's physical condition or response to the service delivery. (1-27-91)

ii. Notify the Bureau of Medicaid Policy and Reimbursement within forty-eight (48) hours of any changes in the recipient's condition or if the recipient is hospitalized at any time. Failure to submit such notification will result in recoupment of payment for private duty nursing services. (7-1-94)

iii. Evaluate changes of condition. (1-27-91)

iv. Provide services in accordance with the physician's plan of care. (1-27-91)

v. Records are to be maintained in the recipient's home. Failure to maintain such documentation may result in the recoupment of funds paid for undocumented services. Records of care must include: (8-1-92)

(a) The date. (1-27-91)

(b) Time of start and end of service delivery. (1-27-91)

(c) Comments on client's response to services delivered. (1-27-91)

(d) Nursing assessment of recipient's status and any changes in that status per each working shift. (8-1-92)

(e) Services provided during each working shift. (8-1-92)

vi. In the case of L.P.N. providers, document that oversight of services by an R.N. is in accordance with the Idaho Nurse Practice Act and the Rules, Regulations, and Policies of the Idaho Board of Nursing. (1-27-91)

vii. Notify the physician if the combination of Private Duty Nursing Services along with other community resources are not sufficient to ensure the health or safety of the recipient. (1-27-91)

f. Case redetermination for Private Duty Nursing: (8-1-92)

i. Redetermination will be at least quarterly. Each recipient's medical records will be reviewed by the Bureau of Medicaid Policy and Reimbursement for medical necessity criteria found in Section 100. (7-1-94)

ii. The purpose of redetermination for Private Duty Nursing is to safeguard against unnecessary care and services and to determine that the care being provided is medically necessary and safe and effective in the home setting. (8-1-92)

g. Factors assessed for redetermination: (8-1-92)

i. That the recipient can and is being maintained in their personal residence and receive safe and effective services through Private Duty Nursing services. (8-1-92)

ii. That recipient's receiving Private Duty Nursing services have medical justification and physician's orders. (8-1-92)

iii. That there is an updated written plan of care, signed by the attending physician. (8-1-92)

iv. That the attending physician has determined the number of Private Duty Nursing hours needed to ensure the health and safety of the recipient in his home. (8-1-92)

v. That all Private Duty Nursing services are provided according to Subsection 100.05.b. (8-1-92)

vi. That the service or services being provided include at least one of the nursing tasks outlined in Subsections 100.05.a.i through 100.05.a.iv. (8-1-92)

h. Provide responsibilities for Private Nursing redetermination: (8-1-92)

i. To submit a current plan of care to the Bureau of Medicaid Policy and Reimbursement at least quarterly or as the recipient's needs change. Failure to submit an updated plan of care to the Bureau prior to the end date of the last authorization will cause payments to cease until completed information is received and evaluated and authorization given for further Private Duty Nursing services. The plan of care must include all requested material outlined in Subsection 100.05.c. (7-1-94)

ii. To inform the Bureau of Medicaid Policy and Reimbursement within ten (10) calendar days of any changes in service needed by the recipient which qualify that recipient for Private Duty Nursing services. The Bureau must receive notification within ten (10) calendar days. Failure to report these changes in patient status will result in the recoupment of funds paid to the Private Duty Nursing provider. (8-1-92)

i. Nonmedical transportation, such as to the grocery store, is not reimbursable by the Medicaid Program. Medical transportation of the recipient, such as to a physician's office, is not a covered service under the Private Duty Nursing Program but may be covered under the transportation section of the Medicaid Program. (1-27-91)

07. Nutritional Services. Nutritional services include intensive nutritional education, counseling, and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/professional requirements in dietetics as approved by the American Dietetic Association to assure the patient's proper nutrition. Payment is made at a rate established in accordance with Subsection 060.04. Nutrition services: (12-31-91)

a. Must be discovered by the screening services and ordered by the physician; and (1-27-91)

b. Must be medically necessary; and (1-27-91)

c. Must not be due to obesity; and (1-27-91)

d. If over two (2) visits per year are needed, must be authorized by the Medicaid Program prior to the delivery of additional visits. (1-27-91)

08. Drugs. Drugs not covered by the Idaho Medicaid Program: (1-27-91)

a. Must be discovered as being medically necessary by the screening services; and (1-27-91)

b. Must be ordered by the attending physician; and (1-27-91)

c. Must be authorized by the Medicaid Program prior to purchase of the drug. (1-27-91)

09. Oxygen and Related Equipment. Oxygen and related equipment are subject to Subsections 107.01.a., 107.01.b. and 107.01.d. and Subsection 107.04. and 107.05. except when discovered during screening services; physician ordered and meet the following requirements: (8-1-92)

a. Oxygen services, PRN or as ordered on less than a continual basis, will be authorized for six (6) months following receipt of medical documentation from the attending physician as to an acute or chronic medical condition which requires oxygen support to maintain respiratory status. Medical documentation will include a diagnosis, oxygen flow rate and concentration and an estimate of the frequency and duration of use. (8-1-92)

b. Portable oxygen systems may be covered to complement a stationary system if the recipient is respirator dependent, or the attending physician documents the need for a portable oxygen system for use in transportation. (1-27-91)

c. Laboratory evidence of hypoxemia is not required. (1-27-91)

101. SPECIAL SERVICES RELATED TO PREGNANCY. When ordered by the patient's attending physician, nurse practitioner or nurse midwife, payment of the following services is available after confirmation of pregnancy and extending through the end of the month in which the 60th day following delivery occurs. (1-3-89)

01. Risk Reduction Follow-up. Services to assist the client in obtaining medical, educational, social and other services necessary to assure a positive pregnancy outcome. Payment is available to licensed social workers, registered nurses and physician extenders either in independent practice or as employees of entities which have current provider agreements with the Depart-

ment. A single payment for each month of service provided is made at a rate established in accordance with Subsection 060.04. (12-31-91)

02. Individual and Family Social Services. Services directed at helping a patient to overcome social or behavioral problems which may adversely affect the outcome. Payment at a rate established under the provisions of Subsection 060.04. is available for two (2) visits during the covered period to a licensed social worker qualified to provide individual counseling according to the provisions of the Idaho Code and the regulations of the Board of Social Work Examiners. (12-31-91)

03. Nutrition Services. Intensive nutritional education, counseling and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/professional requirements in dietetics as approved by the American Dietetic Association to assure the patient's proper nutrition. Payment for two (2) visits during the covered period is available at a rate established under the provisions of Subsection 060.04. (12-31-91)

04. Nursing Services. Home visits by a registered nurse to assess the client's living situation and provide appropriate education and referral during the covered period. A maximum of two (2) visits in the covered period is provided. Payment is made at a rate established in accordance with Subsection 060.04. (12-31-91)

05. Maternity Nursing Visit. Office visits by a registered nurse, acting within the limits of the Nurses Practices Act, for the purpose of checking the progress of the pregnancy. These services must be prior authorized by the Department's care coordinator and can be paid only for women unable to obtain a physician to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized. Payment is made at a rate established in accord with Subsection 060.04. (12-31-91)

06. Qualified Provider Risk Assessment and Plan of Care. When prior authorized by the Department care coordinator, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of antepartum care. Such payment is made at rates established in accord with Subsection 060.04. to the qualified providers established in Section 102. (12-31-91)

102. QUALIFIED PROVIDERS OF PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN. The Department will enter into provider agreements allowing presumptive eligibility determination with providers meeting the qualifications of Section 1920(b)(2)(d) of the Social Security Act, and who employ individuals who have completed a course of training supplied by the Department. (1-3-89)

103. (RESERVED).

104. HOSPICE. Medical assistance will provide payment for hospice services for eligible recipients. Reimbursement will be based on Medicare program coverage as set out in this section. (10-24-88)

01. Definitions. Inherent in these definitions is that a patient understands the nature and basis for eligibility for hospice care without an inappropriate and explicit written statement about how the impending death will affect care. Though only written acknowledgment of the election periods is mandated, it is required that the patient or their representative be fully informed by a hospice before the beginning of a recipient's care about the reason and nature of hospice care. (10-24-88)

a. Attending Physician. A physician who: (10-24-88)

i. Is a doctor of medicine or osteopathy; and (10-24-88)

ii. Is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care. (10-24-88)

b. Benefit Period. A period of time that begins on the first day of the month the recipient elects hospice and ends on the last day of the eleventh successive calendar month. (10-24-88)

c. Bereavement Counseling. Counseling services provided to the individual's family after the individual's death. (10-24-88)

d. Cap Amount. The maximum amount of reimbursement the Idaho Medicaid Program will pay a designated hospice for providing services to Medicaid recipients per Subsection 104.12. (12-31-91)

e. Cap Period. The twelve (12) month period beginning November 1 and ending October 31 of the next year. See overall hospice reimbursement cap referred to in Subsection 104.12. (12-31-91)

f. Election Period. One of eight (8) periods within the benefit period which an individual may elect to receive Medicaid coverage of hospice care. Each period consists of any calendar month, or portion thereof, chosen within the benefit period. (10-24-88)

g. Employee. An individual serving the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is appropriately trained and assigned to the hospice unit. "Employee" also refers to a volunteer under the jurisdiction of the hospice. (10-24-88)

h. Freestanding Hospice. A hospice that is not part of any other type of participating provider. (10-24-88)

i. Hospice. A public agency or private organization or a subdivision thereof that: (10-24-88)

i. Is primarily engaged in providing care to terminally ill individuals; and (10-24-88)

ii. Meets the conditions specified for certification for participation in the Medicare and Medicaid programs and has a valid provider agreement. (10-24-88)

j. Independent Physician. An attending physician who is not an employee of the hospice. (10-24-88)

k. Representative. A person who is, because of the individual's mental or physical incapacity, legally authorized in accordance with state law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill individual. (10-24-88)

l. Social Worker. A person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education. (10-24-88)

m. Terminally Ill. When an individual has a certified medical prognosis that his or her life expectancy is six (6) months or less per Subsection 104.02. (12-31-91)

02. Physician Certification. The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures: (10-24-88)

a. For the first period of hospice coverage, the hospice must obtain, no later than two (2) calendar days after hospice care is initiated,

written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician (if the individual has one). The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six (6) months or less and the signature(s) of the physician(s). (10-24-88)

i. In the event the recipient's medical prognosis or the appropriateness of hospice care is questionable, the Department has the right to obtain another physician's opinion to verify a recipient's medical status. (10-24-88)

b. For any subsequent election period, the hospice must obtain, no later than two (2) calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the interdisciplinary group. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six (6) months or less and the signature(s) of the physician(s). (10-24-88)

c. The hospice must maintain the monthly certification statements for review per Section 190., governing surveillance and utilization. (12-31-91)

d. The hospice will submit a physician listing with their provider application and update changes in the listing of physicians which are hospice employees, including physician volunteers, to the Bureau. The designated hospice must also notify the Medicaid program when the designated attending physician of a recipient in their care is not a hospice employee. (8-1-92)

03. Election Procedures. If an individual elects to receive hospice care, he or she must file an election statement with a particular hospice. An election statement may also be filed by a legal representative or guardian per Section 15-5-312, Idaho Code. (10-24-88)

a. An election to receive hospice care will be automatically renewed after the initial election period and through any subsequent election periods without a break in care as long as the individual remains in the care of a designated hospice and does not revoke the election. (10-24-88)

b. A recipient who elected less than eight (8) monthly election periods within the benefit period may request the availability of the remaining election periods. When the following conditions are met, the request will be granted. (10-24-88)

i. The hospice days available did not exceed two hundred and ten (210) days in the benefit period due to the loss of financial eligibility. (10-24-88)

ii. The recipient or the legal representative did not change hospices excessively per Idaho Health and Welfare Department Rules Section 104.06.a. (7-1-94)

iii. The recipient or the legal representative did not revoke hospice election periods more than eight (8) times per Idaho Health and Welfare Department Rules Section 104.05. (7-1-94)

c. An individual may receive hospice services from the first day of hospice care or any subsequent day of hospice care, but a recipient cannot designate an effective date that is earlier than the date that the election is made. (7-1-94)

d. A recipient must waive all rights to Medicaid payments for the duration of the election period of hospice care, with the following exception: (10-24-88)

i. Hospice care and related services provided either directly or under arrangements by the designated hospice to the recipient. (10-24-88)

ii. Any Medicaid services that are not related or equivalent to the treatment of the terminal condition or a related condition for which hospice care was elected. (10-24-88)

iii. Physician services provided by the individual's designated attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services. (10-24-88)

04. Election of Hospice. The election statement must include the following items of information: (10-24-88)

a. Identification of the particular hospice that will provide care to the individual. (10-24-88)

b. The individual's or representative's acknowledgement that he or she has been given a full understanding of hospice care. (10-24-88)

c. The individual's or representative's acknowledgement that he or she understands that all Medicaid services except those identified in Idaho Health and Welfare Department Rules Section 104.03.d are waived by the election during the hospice benefit period. (7-1-94)

d. The effective date of the election. (10-24-88)

e. The signature of the individual or the representative and the date of that signature. (10-24-88)

05. Revocation of Hospice Election. An individual or representative may revoke the election of hospice care at any time. (10-24-88)

a. To revoke the election of hospice care, the individual must file a signed statement with the hospice that includes the following: (10-24-88)

i. The individual revokes the election for Medicaid coverage of hospice care effective as of the date of the revocation. (10-24-88)

b. Upon revocation of the hospice election, other Medicaid coverage is reinstated. (10-24-88)

06. Change of Hospice. An individual may at any time change their designated hospice during election periods for which he or she is eligible. (10-24-88)

a. An individual may change designated hospices no more than six (6) times during the hospice benefit period. (10-24-88)

b. The change of the designated hospice is not considered a revocation of the election. To change the designation of hospice programs, the individual must file during the monthly election period, with the hospice from which he or she has received care and with the newly designated hospice, a dated and signed statement that includes the following information: (10-24-88)

i. The name of the hospice from which the individual has received care; (10-24-88)

ii. The name of the hospice from which he or she plans to receive care; and (10-24-88)

iii. The effective date of the change in hospices. (10-24-88)